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AUTHOR Ensminger, David
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ABSTRACT

This training manual, intended for use by college students to learn peer counseling techniques, contains four sections. The first section provides an introduction to peer counseling. Effective therapeutic communication, solving a problem, basic counseling techniques, communicating styles, and the limitations of peer counseling are discussed. The second section contains information and strategies for counseling those with problems related to alcohol and drugs. Diagnosis of chemical dependence and chemical abuse are discussed, and traits are listed to help the peer counselor identify behaviors. Substance abuse is also discussed as it relates to a group's collective behavior. Information is provided for confronting an abuser, and for contacting local support groups and treatment facilities. Information also is presented for ways to avoid over-indulgence and development of an alcohol problem. The third section looks at the problems of suicide and depression. Recognizable signs and symptoms of depression are delineated. Strategies are presented for handling a depressed individual. Four types of danger signals for suicide are examined, and ways to prevent suicide from occurring are discussed. The fourth section deals with rape, date rape, and sexual assault. The problem is described, and warning signs are provided for prevention education. Attitudes that males need to change, and attitudes that females need to portray are listed. Three phases of date rape are identified and discussed. The concept of rape trauma is defined and information is provided for working with a rape victim. (LLL)

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GREEKS ASSISTING GREEKS

(G.A.G.)

TRAINING MANUAL

Written by:
David Ensminger

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" ... he who can look on the loneliness of the world and share its sorrow, and realize something of the wonder of both, is in immediate contact with diving things..."

-Oscar Wilde-

"...How do I feel at the end of the day?"
"Are you sad because you're on your own?"
"No. I'll get by with a little help from my friends."

-Beatles-

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Introduction to Peer Counseling

Peer counseling programs are designed to deliver counseling services directly to a group by training group members in the counseling process. In many cases, individuals in distress will seek out friends or associates before professionals. In knowing this, peer counselors serve two purposes. (1) They can meet with the individual and provide a peer counseling relationship for minor problems and when necessary, refer them to a professional. (2) They are available to deal with crisis situations until professional help arrives.

It is important to remember that peer counseling programs are designed to be preventive rather than therapeutic. The preventive element of peer counseling comes from early identification and intervention. Because peer counselors are members of the groups they serve, they have more direct contact and can identify group members who are in distress. By intervening at an earlier stage, the individual may avoid development of a more dysfunctional behavior.

The Peer Counseling Process

The objectives of a peer counseling interaction are to establish rapport, understand the problem, prevent self, and socially disruptive behavior, increase functional coping skills and reduce dysfunctional coping skills.

1) Rapport

Rapport is an essential part to any relationship, however, in a peer counseling situation, rapport is a cornerstone. Without rapport, trust, and faith, the peer counseling relationship is not established. Rapport is gained through empathy, warmth, non-judgmental acceptance, and acknowledging how the client currently is in dealing with the problem. Remember peer counseling is person focused, not problem focused.

2) Understanding

Gaining insight into the person's problems requires the peer counselor to interview the person. The goal of the interview is to try to understand how the individual's perceptions of the problem match their current behaviors. During this phase, information is gained through verbal and non-verbal observations.

3) Identifying the Problem

Helping the individual recognize the source of the distress will require the peer counselor to make an hypotheses based on information and observations of the "client." After generating some possible sources for the discomfort, the peer counselor needs to test them out. In some cases, multiple problems seem to be contributed to the distress. In cases like this, listing all the problems will allow the peer counselor and the individual to focus on the more serious areas. Problem listing also allows the peer counselor to identify one major area which may be the source of all the other problems.

4) Making a Healthy Change

Creating a healthy change may require a change in one, all or a combination of the following areas:

A) Insight A change in perception of the problem or new information that may lead to a solution.

B) Skills and Behaviors Creating new coping patterns or strategies for existing problems. This may require learning new and/or more functional behaviors.

C) Environmental Often a change in current physical and social environment is necessary. This includes changing physical activity and social practices.

D) Acceptance In some situations, the only alternative is accepting that the current reality is unchangeable. By accepting this, the individual can construct ways of working with the situation instead of against it.

Effective Therapeutic Communication

Communication is the basis of any relationship, however, in a helping relationship, communication is the keystone. A peer counselor must employ various communication strategies ranging from active listening to interviewing. Communication in a peer counseling process goes beyond just talking and listening, some of the additional components include:

1) Understanding Human Nature

A) Identifying and understanding motives and reasons for behavior.

B) Pay attention to statements of feelings, attitudes, and non-verbal behaviors, these often give insight into motives.

C) Do not judge motives as right or wrong, just identify and provide insight.

D) Maintain a "healthy degree of skepticism." Clients may consciously or unconsciously distort. Try to understand and determine motives.

2) Understanding Your Own Attitudes

Be aware of your own feeling and attitudes, discover your own prejudices, consciously evoke a non-judgmental attitude.

3) Having Objectives and Goals in Advance

A) Be sure you thoroughly understand the situation. Don't be so anxious to help that you miss important details.

B) Remember that the direct approach on revealing your objectives is not always the way to go.

4) Having Good Interview Skills

A) Pay attention to what is said, but also what is not said (gaps in stories, tension anxiety.)

B) Use open ended questions. These type of questions encourage communication.

C) Provide for privacy and confidentiality.

D) Watch your time. Do not end abruptly because you need to be somewhere or the person needs to leave.

E) Maintain a balance between developing too much dependency and appearing avoidant or unresponsive. Remember that being over friendly and making promises you can't keep will only destroy your credibility.

Solving a Problem

Most of the situations a peer counselor will face are ones where the individual needing help can easily identify the problem. In these situations, the individual may just need assistance in developing a solution to the problem. However, many people lack problem solving skills or find it difficult to apply them to a personal/emotional problem. When a peer counselor comes in contact with a problem such as this, their role becomes one of leading the individual through the steps of problem solving. Theses steps include:

1) Defining the Problem

   During this step the problem is looked at objectively and rationally. The individual is asked to put their feelings aside for the time being. The problem needs to be defined clearly and in specific exact terms.

2) Determining the Desired Goal or Objective

   In this phase, the individual must decide what the preferred outcome would be at the present time.

3) Listing all Solutions or Options

   Brainstorm and generate all possible solutions to the problem. During this step, all options are listed, even those that seem unrealistic or impossible.

4) Considering Probability of Success with Each Alternative

   At this time, the individual discusses all the potential outcomes for each option. Consider all outcomes that may occur and discuss probability of success for all alternatives.

5) Choosing the Best Probable Solution

   Remember the best probable solution may not always be the desired solution. Problem solving requires solutions which will produce resolution to the problem. The best solution should also be the one which provides the best outlook for future growth.

6) Implementing

Once the choice has been made, do it. Waiting will only reduce the chance for successful resolution. If the selected alternative does not work, go back and repeat steps 4 and 5.

7) Evaluating

Once the problem is resolved, evaluate the outcomes and the decision making process. Look for ways to improve the process and how to handle similar situations in the future.

BASIC COUNSELING TECHNIQUES

1) Establish rapport. Be a person the individual can like. Become a real person to him/her. Be warm, friendly, and outgoing.

2) Be honest. If you don't know, say "I don't know."

3) Be yourself. Don't intellectualize.

4) Be consistent. Establish limits and expectations.

5) Don't lecture. Avoid giving them a feeling they are being criticized.

6) Listen. Most people are rarely listened to. Show an interest in what he/she brings to you. Don't rush client.

7) Deal with concrete everyday occurrences. Try to be immediately helpful.

8) Know the language of the age-group represented.

9) Allow for dependence, but work toward independence. Work through ambivalence.

10) Allow for acting out. Be prepared to deal with it through challenging and controlling it in socially acceptable ways. Encourage reality testing.

11) Build trust and confidence by being open, frank, fair and dealing with the problem.

12) Develop an ability to empathize. Do not condone unrealistic attitudes of behavior. Avoid over-relating. Be accepting of individual, not behavior.

13) Recognize your anger with them if their behavior provokes you. Don't hide your feelings behind a facade.

14) Avoid exhorting the individual to "open up," "trust me," "if you rely on me and share things with me, all will go well." This develops mistrust.

15) Don't moralize. Respect their rights. Keep an open mind.

16) Be aware of and ready to deal with the intense emotional feelings of an individual.

17) Recognize their limitations and don't push them beyond the limits of their capabilities.

18) Recognize your limitations and refer client to professional when necessary.

19) Don't give advice. Give alternatives. Let them make the decisions.

20) Provide motivation and stimulation.

Focus in peer counseling is not on techniques but on understanding the person as a human being and helping him/her to understand and experience him/her self as a responsible person who has value and worth. He/she will then solve his/her problems in a meaningful way and begin to clarify his/her own values and commitments to life.

Remember: Peer counseling is person focused, not problem focused.

Communicating Styles

In many cases peer counseling can require different styles of communicating. Styles can range from an individual just venting to a group looking for a resolution to a problem.

1) **Venting**

A) Goal The goal of venting is to let off steam. In some instances an individual needs to get his/her frustration out verbally. In most cases of venting, once the process is over the individual solves the problem on their own.

B) Roles In this style, there are two roles, the speaker (i.e. one who let's off steam) and the listener who listens and supports.

C) Problems to Avoid In this process avoid being intimidated by the speaker. Also avoid problem solving, minimizing problems, and giving advice.

2) **Discussion**

A) Goal Help the individual explore their own thoughts and feelings. Give insight and information on the subject. Understand the other person's point of view.

B) Roles Individuals involved alternate between being the speaker and the listener. No one person should dominate, however, it is good to allow the client to express themselves without interruptions.

C) Problems to Avoid Be careful not to debate an issue if you disagree. Give validation to your perception and move one. Do not judge. Avoid problem solving.

3) **Problem Solving**

A) Goal Have the peer counselor try to encourage person to define the problem. Clarify and suggest possible solutions.

B) Roles Peer Counselor asks questions, reflects back what the client reports, gives insight to outcomes to possible solutions, and acts as a "sounding board." In cases where the problem exists between two people who are both present in the meeting, the peer counselor serves as mediator, evaluator, and unbiased objective viewer.

C) Problems to Avoid Always avoid solving the problem for the person(s); this only creates dependency. Do not debate or judge the individual's solution to problem. Only make them aware of potential outcomes.

Know Your Limitations

It is important to remember that the training that peer counselors receive in no way makes them a professional. It becomes important to know your own limitations and remember peer counseling serves as preventive role more than a therapeutic role.

Peer counselors are faced with situations where their skills will allow them to meet the immediate crisis need, but do not allow for the long term interventions required for therapeutic change. Some of these situations include:

1) life-endangerment/suicide
2) sexual assault/abuse
3) long-term re-occurring problem
4) violent acting out
5) severe alcohol and drug abuse
6) extreme anxiety or stress

7) family abuse/marriage problems
8) situations where peer counseling is not meeting the individual's needs

However, some cases or problems lend themselves to being solved more easily by a peer counselor than a professional counselor. Some of these include:

1) relationship problems
2) acute anxiety
3) loneliness
4) peer communication
5) group crisis intervention
6) social support development
7) minor problem solving
8) venting of emotions
9) adjusting to university environment
10) identification of individuals experiencing severe distress

Alcohol and Drugs

The number of students who eventually die of alcohol related causes equals the number of students who will go on to receive Masters and Doctorate degrees.

$4.2 billion is spent annually by college students to purchase alcohol. This amount is greater than the combined moneys spent nationally on scholarships, fellowships, and maintenance of university libraries.

Universities have not eluded the problems associated with alcohol and drugs. The fact is that alcohol is often considered part of campus life.

Society associates the use of drugs including alcoholas part of the movement from adolescence to adulthood. Individuals often view alcohol as a symbol of freedom and independence. Students usually believe that alcohol and other drugs are required to have a "good time", however, they rarely consider the negative effects associated with use and abuse of drugs including alcohol.

Consequences from overuse of alcohol and other drugs include, sexual assaults, addiction, acquisition of STDS, arrest, lower school and work performance, loss of relationships, bodily injury and death.

The Problem

* Problems with alcohol consumption account for 7% of freshman drop-outs.

* Four percent of all college students drink daily.

* Forty seven percent of college students report engaging in unwanted sex due to alcohol consumption.

* Fifty-five percent of women and 75% of men involved in acquaintance rapes report they were using alcohol or drugs at the time of the attack.

* Individuals between the ages of 16-24 are responsible for 42% of alcohol and drug related auto fatalities in the United States. This group makes up only 20% of all licensed drivers in the United States.

* Sixty-five percent of unwanted college student pregnancies were conceived while the female was intoxicated.

* Fourteen percent of NSU students have had five or more drinks in one sitting within the last two weeks.

* Thirty four percent of NSU students will use alcohol at least once a week.

* An estimated 43 NSU students will drive while intoxicated every week during the fall and spring semesters.

* During the next academic year, an estimated 540 NSU female students will be taken advantage of sexually at least once while intoxicated.

Understanding Substance Abuse and Dependency

Physical Addiction- Refers to cell structure change such that reduction of dosage or elimination of use results in classic withdrawal symptoms. Withdrawal symptoms are similar to those a person experiences when they over do it on a Saturday night (e.g. nausea, vomiting, muscle aches, diarrhea, fever, tremors). Once a person is physically addicted, avoiding withdrawal is one motivation for continued use of a drug. Physical addiction results from chronic use.

Psychological Addiction- User perceives a reduced sense of well-being upon decreasing amounts or elimination of the substance. Attempting to restore a sense of well-being is one motivation for continued use. "I feel better about myself when I drink." "I am more social when I smoke Marijuana." "I need a couple of lines to get the job done."

Physical Tolerance- Refers to the fact that the user needs to take larger quantities, of a substance or take the substance more often, in order to achieve the desired effect.

Behavior Tolerance- User has learned how to not act "drugged" while under the influence of drugs or alcohol. The person has learned to cover up some of the physical effects of drugs and alcohol. "Funny thing, people try not to act under the influence of drugs or alcohol. If you don't want to appear drunk or drugged then why use?"

Three Major Components of Addiction

All three components relate to the medicator of choice. The Medicator refers to the substance, activity, or behavior the person uses to achieve an altered state or to relieve distress.

1. Tolerance- Refers to physical tolerance, the idea that the user needs more of the substance to achieve desired effects. Usually a 50% increase from original dosage is required.

2. Withdrawal- Person experiences physical and psychological problems from abstinence of the substance or from overuse of the substance (i.e. loss of self esteem, loss of well-being, headaches, nausea, etc).

3. Loss of Control- This refers not only to problems while using substance such as, inability to predict out comes of behavior, black-outs, violation of personal rules and criminal misconduct, but also the effect the substance has on the person's family, social, occupational, and global responsibilities due to withdrawal effects and intoxication.

These components make an effective model because they allow the theory of addiction to include types of addiction where the medicator is not a chemical (i.e. food, sex, exercise, etc.).

Disease Components to Addiction

Primary Disease- Dependency is not a secondary symptom to another disease. Addiction may originate from some other disorder or problem, however once a person becomes dependent, the addiction becomes its own separate disease with its own prognosis and treatment.

Progressive Disease- This disease becomes progressively worse. It will effect a person physically, emotionally, psychologically, and spiritually.

Chronic Disease- NO CURE - Recovery is achieved only through abstaining from mood altering chemicals. Hence the idea "once an alcoholic always an alcoholic." A person only becomes a recovering substance abuser when they stop using mind altering chemicals.

Fatal Disease- If a person does not go into recovery the prognosis is death. Prior to death, the individual may suffer serious health problems including liver problems, brain damage, heart damage, sexual dysfunctions, and sterilization.

Progression of Chemical Dependency

Most addictions will progress through 4 distinct phases. These phases are:

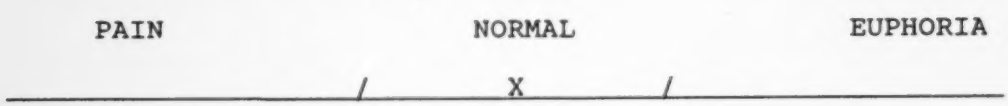
Phase 1. Learning the mood swing.

Phase 2. Seeking the mood swing.

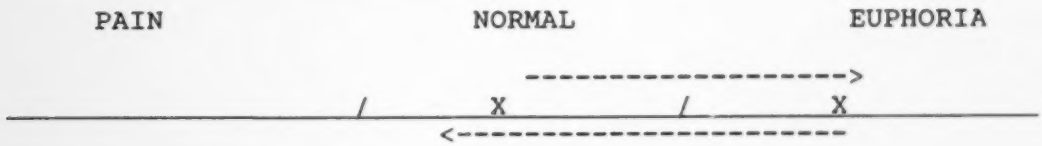
Phase 3. Harmful Dependency.

Phase 4. Using to feel normal.

This theory purports the view that people function between two extremes, Pain and Euphoria. [1]



Phase #1 Learning the Mood Swing

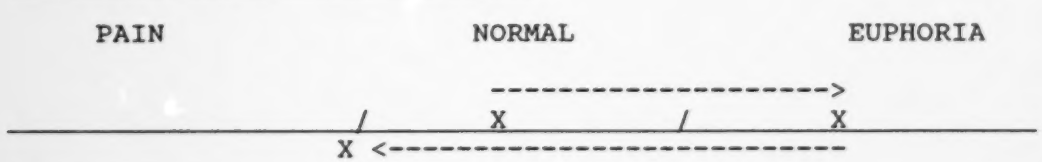


1. The indivdual discovers and learns that using chemicals or medicators provides short-term mood, behavioral, and subjective changes. Often the person experiences a relaxation of their social inhibitors.

2. The individual also realizes that use of the medicator will produce these desired changes consistently. Person begins to develop a relationship between medicator and desired effects.

3. The individual can control the subjective and physical effects the medicator produces by controlling the use of the substance. At this phase the person is aware of the idiosyncratic changes that the substance produces and how they react to the substance.

Phase #2 Seeking the Mood Swing

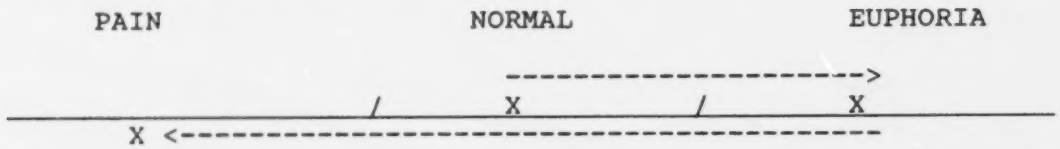


1. The individual begins to use the medicator in socially and culturally acceptable ways. He/she adheres to personally defined rules (i.e. " I won't drink before 5:00 P.M.").

2. The individual remains in control of use and can still predict outcomes while using the medicator. User may experience minor withdrawal effects such as hangovers, however, he/she still maintains the ability to behave socially, occupationally, and interpersonally. The user's overall global functioning remains normal or suffers little.

3. Most individuals who use substances or medicators remain in this phase. Society usually refers to these people as social users.

Phase #3 Harmful Dependence

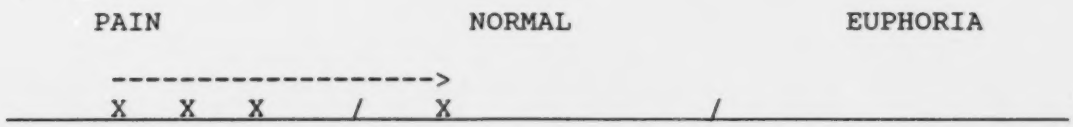


1. The individual begins to violate social and personal regulations that govern their use of the medicator. As the user violates their self-imposed guidelines, he/she is unable to control personal outcomes from their use. As a result the user often engages in behaviors that violate personal ethics and values such as sexual misconduct, criminal activities, and drunk driving. The individual experiences emotional trauma from the breaking of personal values. Often this in and of itself can lead to more medicating behavior.

2. The individual begins to find ways to defend their substance use. The user often rationalizes their substance use and negative effects produced by the medicator. By masking the distress produced by chemical use, the individual can suppress and even ignore the problems that result. Examples: "Hey everybody has hangovers." "I really did not think I could make an "A" in that class anyway." "I really did not like him." "She was drunk and wanted to have sex with me." The user may also ask a significant other to assist him/her in covering up the problems that result from substance use. This often is the beginning of the "Co-dependent" relationship.

3. Chemical use begins to effect the individual's occupational, social,interpersonal and general global functioning. The user begins to spend more time acquiring and using substances.

Phase #4 Using to Feel Normal



1. The individual uses the chemical to survive. The user has become physically addicted to the substance. Frequency of mental blackouts increases. The addict develops paranoid behaviors. Tolerance continues to increase, as a result, the addict risks overdose or toxic levels of the chemical. Life focuses around obtaining and using the medicator. The addict

may loose the will to live. The individual has become emotionally, physically, psychologically, and spiritually bankrupt.

Diagnosis of Chemical Dependence and Chemical Abuse

Substance Dependence [2]

Dependence exists if the person has three of the following traits that have persisted for one month or have occurred repeatedly over a six month period.

1. Substance often taken in larger amounts or over a longer period than person intended.
2. Persistent desire, or one or more unsuccessful efforts to cut down or control substance use.
3. A great deal of time is spent in activities necessary to get the substance or recovering from its effects.
4. Frequent intoxication or withdrawal symptoms when expected to perform major role obligations at work, school, or home, or when substance use is physically hazardous.
5. Important social, occupational or recreational activities reduced or given up because of substance use.
6. Continued substance use despite knowledge of having a persistent or recurrent social, psychological, or physical problem that is caused or exacerbated by the use of the substance.
7. Need for markedly increased amounts of the substance (at least 50% increase) in order to achieve intoxication, or markedly diminished effect with continued use of the same amount.
8. Characteristic withdrawal symptoms (nausea, vomiting, muscle aches, sweating, diarrhea, fever etc.).
9. Substance often taken to relieve or avoid withdrawal distress.

Substance Abuse

Chemical abuse exists if one of the following persists for at least a month, or has occurred repeatedly over a longer period of time.

1. Continued substance use despite knowledge of having a persistent or recurrent social, psychological, or

physical problem that is caused or exacerbated by the use of the substance and has never been diagnosed as substance dependent.

2. Recurrent use in situations in which use is physically hazardous (e.g., driving while intoxicated) and has never been diagnosed as substance dependent.

3. Never met criteria for substance dependence for this substance.

What To Look For In An Individual

The problem of substance abuse often goes unnoticed. It is important to know identifying behaviors that are associated with chemical abuse and dependency. By recognizing symptoms or behaviors that are correlated to substance abuse, individuals can be easily identified and treated. Some of the behaviors exhibited by chemical abusers are listed below.

1) Chronic absenteeism from school or work.

2) Decrease in school performance or work performance. This can either occur quickly or can occur over time.

3) Individual becomes defensive and argumentative when confronted on drug or alcohol use.

4) General irresponsibility. Ignores obligations and avoids responsibility.

5) Gradual withdrawal from social activities.

6) Frequent encounters with law enforcement officials.

7) Drug or alcohol use results in loss of relationship(s).

8) Frequent use of alcohol or drugs or use of substance as a means of dealing with problems.

9) Experiences black outs (i.e. memory loss while using substance).

10) Drinks more often or in greater amounts than planned; constantly breaks self-imposed limits.

11) Uses drugs or alcohol to get started in the morning and/or craves drugs or alcohol at particular times during the day.

12) Individual's social and personal activities surround drug or alcohol use. Conversations center around personal use patterns or patterns of friends.

13) Frequently experiences withdrawal symptoms associated with substance abuse (i.e. hangovers, nausea, medical problems).

What to Look for in Groups

Society usually views chemical dependency as an individualistic problem. However, alcohol and drug problems can and do go beyond the individual. Often the problem focuses around student living groups. In order to determine if a living group has an alcohol or drug problem, group members need to look beyond each individual's behavior to the group's collective behavior. This requires members to consider how alcohol and drugs relate to the group's attitudes, behaviors, and daily activities. The following are substance abuse warning signs for living groups.

1) Alcohol is the main focus of social activities.

2) The group or individuals of the group pride themselves on having a reputation for wild drunken parties.

3) More emphasis is placed on alcoholic beverages than non-alcoholic beverages or food when social functions are planned. A large percentage of the group's budget is spent on alcohol or drugs.

4) A large portion of the group drinks to get drunk. The group encourages heavy drinkers to get drunk and pressures nondrinkers to drink.

5) The group ignores or makes excuses for individuals who drink excessively.

6) The group uses alcohol or drugs as an excuse for sexually aggressive behavior or sexual exploitation in relationships.

7) The group believes it is inappropriate to question an individual's consumption habits.

8) The whole group has problems with authorities due to drug or alcohol use.

9) The group's behavior becomes more violent or disruptive when members use alcohol or drugs.

10) The group's conversations revolve around members' alcohol and drug related behaviors.

11) The group denies or refuses to evaluate their drug and alcohol use.

How to Help

Helping a person who is having difficulty with drugs or alcohol requires a firm but understanding approach. Substance abusers have an ability to generate multiple explanations for their behavior, none of which will address their drug or alcohol use. The user's denial is the first obstacle to overcome. Users will admit to taking a substance, however, they will deny that their substance use has produced negative consequences. Because of the denial and rationalization, convincing an abuser they have a problem can be an arduous task. The following are some points to consider when confronting an abuser.

1) Before confronting the individual, gain support from family, friends, and the organization's members. "The simple fact is, if your own organization is not willing to back you, the chances of the person being convinced of the problem by you alone are slim. However, one person trying to help is better than none.

2) It is important to confront the denial directly. Giving credit to any excuses allows the user to avoid facing the real problem.

3) Be prepared to evaluate your own drug and alcohol consumption, but, do not allow the abuser to use this information as a weapon against you. Firmly remind the person that you are here to talk about their alcohol or drug use, not yours.

4) Present the facts. It is better to give specific incidents of how the alcohol and drug use has negatively affected the person, others, or the group. Remember, express concern over the individual's use and negative effects experienced.

5) Be specific. If the person was drunk say "you were drunk." Don't judge or be moralistic; this will only cause the person to become defensive.

6) Don't ask questions. The user may not have the answer and you open yourself up for an argument.

7) Determine the bottom line. The organization must set a sanction if the user does nct seek treatment. This sanction must be firm and the group must be able to uphold it.

8) Have treatment options available to the individual. If necessary, call upon their family to help. Be prepared to take the individual to a counselor, support group, or treatment center.

Local Support Groups and Treatment Facilities

NSU Counseling Center
Room 305 Student Union
357-5621
Monday - Friday 8:00 A.M. - 4:30 P.M.

Alcoholics Anonymous
First United Methodist Church
411 Second St. 2nd Floor
357-1331
Tuesday 6:30 P.M.
Friday 8:00 P.M.
Saturday 8:00 P.M.

Narcotics Anonymous
930 Anita Street
Monday and Friday 7:00 P.M.
Wednesday 8:00 P.M.

Natchitoches Alcohol and Drug Abuse Clinic
116 Hwy. 1 South
Harrington Bldg.
357-3122
Monday - Friday 8:00 A.M. - 4:30 P.M.

Briarwood Solution Center
139 E. Fifth Street
352-9087

Alcoholism and Drug Abuse Hotline
1-800-252-6465

National Institute on Drug Abuse Hotline
1-800-662-4357

Being Responsible

The most reasonable decision one can make about using alcohol is that of "responsible use" with the most responsible use being "non-use." If you use alcohol responsibly, it can be a part of your social activities, without destroying all areas of your life. So if you do decide to drink, here are some ways to avoid over indulgence and the development of an alcohol problem:

1) Remember, drinking should never be the primary focus of your social activities.

2) Respect other's right not to drink.

3) Do not encourage irresponsible behaviors of others; confront them instead.

4) Respect all laws governing alcohol use (i.e. age restrictions, drinking and driving).

5) Set a limit on the number of drinks you will have, and stick to that limit.

6) Drink slowly; limit yourself to one drink per hour (i.e. one drink = one 12 oz. beer, one 6 oz. glass of wine, or one 1 oz shot or mixed drink).

7) Eat before, during, and after alcohol consumption. High protein food slows alcohol absorption into the blood stream.

8) Be aware that prescription medication and other drugs do not mix with alcohol.

9) Be aware of your own personal limits and how alcohol effects you physically, emotionally, and psychologically.

10) Seek help if you think you have a drinking problem or you think a friend may have a problem.

[1] Adapted from Feeling Chart - Dr. Alvera Stern "Innovations in Prevention" Presentation at Northwestern State University 12-13-90.

[2] From DSM-III-R, American Psychiatric Association, American Psychiatric Association. 1987. Pg. 167-169.

DEPRESSION AND SUICIDE

"Why would anyone wish to end something as precious as life? To hate life, and hope every day that every minute would be the last, to look at a little baby and to see the wonder of nature, and still want to die."

A suicidal young man

"...suicide is a dreary and dismal wintry storm within the mind, where staying afloat or going under is the vital decision being debated."

Edwin Shneidman

College students are not immune to depressive episodes or to suicide. The difficulty of moving away from home, loneliness, academic stress, developing new relationships and adjusting to a new environment can be overwhelming for some students. As a result of life changes, students can experience simple blues to major depression. With the onset of depression, suicidal ideations and behaviors often need to be addressed.

The Problem

* In the United States, 30,000 suicides are reported annually.
* More females will attempt suicide, however males are 4 times more likely to die from an attempt than females.
* Two-thirds of all committed suicides in the United States are white males.
* One out of every four women, and one out of every eight males will experience a depressive episode in their lifetime.
* Approximately 17% of all suicides are committed by individuals ages 15-24.
* Researchers indicate that November is a peak month for suicide attempts for the age group 15-29.
* Thirty five percent of suicide victims had been consuming alcohol at the time of death, with two thirds of the victims being legally intoxicated.

Depression - What to Look For

Episodes of depression can range from mild and short periods of the blues to long lasting periods of anhedonism. For some depression can be an emotional response to an overwhelming stress, while for others the feelings seem to have no identifying cause. However the problem manifests itself, there are some recognizable signs of depression. Some of these symptoms include:

1) Obvious unhappiness.
2) Preoccupied with sad thoughts.
3) Irritable or defensive.
4) Feelings of worthlessness, helplessness and hopelessness.
5) Socially withdrawn, self-isolation.
6) Loss of energy, concentration, interest in surroundings, interest in favorite things, interest in sex.
7) Changes in eating habits.
8) Sleep difficulties - insomnia or hypersomnia.
9) Physical complaints.
10) Suicidal ideation. [1]

In some cases, the depressed person may not show typical signs of anhednoism. The individual's basic behaviors may manifest themselves as acting out behaviors. Other behaviors to be aware of include:

1) Defiance.
2) Rebellion.
3) Increased drug use including alcohol.
4) Failing in school.

How to Handle a Depressed Individual

In many cases, college students will experience a depression that stems from a recent developmental stressor. However, some students will experience a depressive episode which could be classified as a disorder. In both cases, the guidelines for intervention and providing help remain the same. The goals in helping a depressed person are to reduce symptoms, produce a more positive life assessment, create a balance between a person's self-approval and approval from others, and help the person gain an equilibrium between self-support and support from others. [2]

1) Symptom Reducing refers to taking effective steps to deal with the observable symptoms (i e inactivity, sleep disorders, appetite and self-neglect). The following includes some ways of combatting symptoms:

a. Involve the person in some daily physical activity away from their dorm or apartment. Examples: walking, bike riding, and stretching. Activity should be non-competitive and last at least 20 minutes.

b. Have the individual set a regular sleep schedule. The individual should sleep between 7-9 hours a day. He/She should be in bed no later than midnight and up before 8:00 a.m.

c. Personal appearance and hygiene need to be kept up. The individual should shower, shave,and wear clean, pressed clothes daily. Females should wear make-up.

d. The individual needs to have 3 well-balanced meals daily. He/She should remove excess sugar, caffeine, and fats from their diet (i. e. sodas, candy, chips, fries, hamburgers, all fast foods).

e. The individual needs to strengthen or develop a social support system. <u>It is important that the person does not become dependent on this system for personal happiness.</u>

2) <u>Positive Life Assessment</u> refers to developing a means of assessing personal accomplishments and failures in a positive way. This includes setting goals and evaluating progress in a realistic manner. The following lists some ways to help a person develop a positive way of assessing their life.

a. The individual should set goals that can be attained with their current ability. The goals should be established daily, weekly, monthly, yearly and for a life-time. Monthly, yearly, and life-time goals need to be flexible.

b. The individual needs to evaluate progress of goals using an objective perception. Failure to achieve goals requires the individual to assess reasons for failure and solutions to problems. Failures can provide as much information about achieving goals as a success can.

c. When successful, the individual needs to validate their own personal role in the accomplishment. This can take form as a reward. The person must also take responsibility for their actions that lead to failure and accept those things they have no control over. This will allow the person to learn that they control their own behavior and that they can change the behavior.

3) Balance between self-approval and approval from others refers to the person developing their own personal reward system and recognition for accomplishments. The individual needs to learn how to praise their own accomplishments. One simple way of teaching this skill is to have the person keep a personal journal in which they record two positive experiences they had for each day. The activity can be either something they accomplished for themselves or something he/she did to help someone else. However, the person can only record two; so they must pick the top two.

4) Balance between self-support and support from others refers to developing an effective social support system which the person can use in times of need, but not use in an unhealthy dependent manner. In developing the system, it is important that supporters not create more helplessness in the depressed person. This requires that supporters encourage and require that the depressed individual take steps to help themselves.

Suicide - What to Look For

Suicidal behavior may result from a prolonged depressive state. The individual may feel that any action they take to change only results in failure. In this condition the person may view suicide as the only alternative to the depression. In other cases, an acute stressor such as the death of a loved one may prove to be too overwhelming, and the person may see suicide as the only end result. Whatever the reason, most victims of suicide do not want to die. Individuals more often report that the suicide attempt was seen as the only alternative or a means of ending their pain. Four types of danger signals give warning of suicide: a catalyst situation, depressive symptoms, verbal signs, and behavioral signs.

1. Catalyst Situation

Any situation which may lead to suicidal thoughts feelings, and actions.

Examples:

A. An extremely pleasant and fulfilling relationship is ended abruptly.

B. Person fired from highly involved job.

C. Straight "A" student fails an exam.

2. Depressive Symptoms

The individual has several of the common symptoms of depression, and expresses a general feeling of helplessness and hopelessness.

3. Verbal Warning Signs

Individuals who are thinking about suicide often verbalize these feelings. It is a myth that those who talk about killing themselves do not actually kill themselves. Any talk or statement that refers to suicide must always be taken seriously.

Examples:

A. "I wish I were dead."
B. "The only way out is to die."
C. "I am not the person I used to be."
D. "I am going to kill myself."
E. "You are going to regret how you treated me."
F. "Nobody needs me anymore."
G. "I am useless."
H. "If _____does/does not happen I will kill myself."
I. "Life has no meaning."
J. "Here take this (valued possession); I won't be needing it anymore."

Take any statement about death or suicide seriously and act on it.

4. Behavioral Warnings

A suicidal person may also give non-verbal signals about wanting to die. In some cases a person may not express their feelings verbally, but only show behavioral warning signs.

Examples:

A. A cherished possession is given away casually.

B. Gets life in order as if going away for a long period of time.

C. Sudden resignation from an important group or organization.

D. Person begins to make own funeral arrangements.

E. Crying or irritability for no apparent reason.

F. Sudden purchase of a gun or prescription drugs.

G. Discovery of suicide notes in books, lockers, and dressers.

H. Engaging in self destructive behavior (i.e.heavy use of drugs including alcohol, multiple sex partners, reckless driving, etc.).

I. Sudden recovery from depression, or sudden answers to problems, but is unwilling to share solution. It is important to remember that people do not get over a severe depression fast or overnight. People who have decided to kill themselves sometimes seem happy or content. They appear happy, but they are usually relieved that the pain they were experiencing will soon be gone. Suicide is not just death, it is often an escape from pain.

J. Previous suicidal attempts:

The most obvious warning signal is a previous attempt to commit suicide. It is important to gain information about previous attempts in order to assess the current risk. The following are key areas to assess in determining the current risk level.

1. Dangerousness

The more lethal the means or plan of previous attempt, the greater the current risk. Example: Did the victim take 5 aspirin or 75 valium?

2. Impression of Dangerousness

Did the person honestly believe that their plan would work? If they believed that the 5 aspirin would kill them, then their current risk increases.

3. Rescue

Did the person try to save self?
Examples:
1. Call a friend.
2. Did they tell someone about the plan?
3. Attempt suicide in area where they could be discovered?

If person did take steps to save self? current risk is reduced.

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4. Timing

The closer the previous attempt is to the current crisis, the greater the risk now.

How to Assess the Current Risk

An easy way to assess a current suicide risk is by using the acronym **SLAP.** **SLAP** stands for Specifics, Lethality, Availability and Proximity.

1. Specifics

Does the individual have a specific "plan of attack?" The more specific a person is in describing how they will kill him/her self, the greater the risk of an attempt.

2. Lethality

Does the person plan to jump off the 20th floor the first floor? Does their plan call for a gun or is the planned method to take pills? The more lethal the method, the greater the risk.

3. Availability

Does the individual have the means of carrying out the plan? How easy is it for the individual to gain access to the proposed method? "Do they own a gun?" "Do they have pills?" etc. Risk increases with availability and access.

4. Proximity

What help does the person have access to? Does the individual have an immediate support system? Is professional help available? As amount of support decreases, current risk increases and vice versa.

Remember, no technique for assessing suicide is foolproof. If you suspect a person may want to commit suicide, do not hesitate to call a professional or the police.

How to Help a Potential Suicide Victim

Helping a person through a suicide crisis requires clear thinking, immediate action, and if possible, additional support from professionals. Suicide intervention literally is a life and death situation. However, most potential suicides can be aborted. Listed below are ways to prevent a suicide from occurring.

1) Build a positive rapport with the person.

[1] Adapted from DSM-III-R, American Psychiatric Association, 1987 (pg. 167-169).

[2] Adapted from Depression, Paul A. Walter, Jr., College Psychotherapy. Editors, Paul A. Grayson, and Kate Couley, The Guilferd Press, 1989.

2) Reinforce the person for seeking help. Use this information as a fact that part of the person wants to live.

3) Be accepting, supportive and above all non-judgmental.

4) Tell the person you want to, and can help them, and that others want to help them too.

5) If contact is over the phone, get essential information who, what, where, and how.

6) Assess the persons current risk level, and contact counseling office or University Police Dept.

7) If the person has a lethal element in their possession, try to persuade them to give it up. However, do not try to restrain a person who has a knife, a razor, a gun, or any object that could harm you. <u>You cannot help someone if you are hurt or dead.</u>

8) Do not leave the person alone until help arrives.

9) If the risk is not great, try some of the following strategies:

   a. Try to help the person identify the problem or source of pain. Do not dwell on the problem or pass it off as not important. If the persons reasons do not make sense, just accept them.

   b. If the person has a significant other in their life (i. e. mother, friend, professor) determine if he/she could help or hinder the situation.

   c. Ask the person how they coped with a similar problem(s) in the past.

   d. Call in a professional. Call the NSU Counseling Office (357-5621) or call University Police (357-5431). They will put you in contact with an NSU counselor. Call the local mental health center (357-3122) or any hot line.

   e. Be sure to set up an appointment and if necessary, escort the person to the appointment.

   f. Most of all, stay with the person until the crisis passes or until professional support arrives.

10) The following are some questions to ask a potential suicide victim:

   a. What ways have you thought of to kill yourself?

b. Have you tried to kill yourself before?

c. Who have you told you want to die?

d. Who do you feel supported by?

e. What pain will go away if you die?

f. Do you think you will really kill yourself?

11) The following are questions and statements <u>not</u> to use:

a. Why questions. "Why do you want to kill yourself?" The person might not know why they want to die. Not knowing may signify additional failure.

b. Do not express how shocked the family will be if the person dies. The family may be the problem.

c. Do not ask the person to feel guilty.

d. Do not ask the person to list reasons for dying or for living. This usually leads to a debate and you may loose both the debate and the person.

"He Kissed her. When he started to unbutton her blouse, she asked him to stop. He continued to unbutton her blouse. She begged him to stop. She told him "No!" emphatically. He continued anyway. He pulled up her skirt and pulled down her panties. While holding both of her arms down with one of his hands, he unzipped his fly and took out his erect penis and penetrated her."

"Mary and John had been dating for two weeks. Both John and Mary had slept with people in the past but they hadn't had sexual intercourse with each other. On their fourth date, after John took Mary out for lobster dinner and then to a wild party to meet some of his friends. The couple went to John's apartment. Mary was wearing a sexy, provocative dress. She had spent a lot of time getting ready because she wanted to look her best for a special evening. After they got to his apartment, they shared a bottle of wine, listened to music, talked, laughed, and kissed. Mary told John what a wonderful time she was having with him. John suggested that they move to his bedroom where they could get more comfortable. She nodded in agreement. In the bedroom, they started dancing erotically and kissing passionately. John caressed Mary's breasts, and Mary moaned. When he started to unbutton her blouse, Mary asked him to stop. He kissed her gently and continued to undress her. She begged him to stop. She told him "No!" emphatically and said that she was not ready for sex with him. He continued anyway, telling her that he knew she wanted it. He told her to relax and that she was really going to like it. John assured Mary that he loved her and that he had been thinking about this moment ever since they first met. He pulled up her skirt and pulled down her panties. While holding both of her arms with one of his hands, he unzipped his fly, took out his erect penis, and penetrated her." *

Consider the two scenarios. Which of these incidents would you personally define as rape?

* From Acquaintance Rape The Hidden Crime Andrea Parrot and Laurie Bechhofer, John Wiley & Sons, Inc. 1991.

Both of the preceding incidents meet the legal definitions of rape.

Typically people think rapes or assaults occur in dark parking lots, parks, alleys, or the "bad" section of town. Society perceives victims as females of questionable character, and in some way inciting the rape. Rapists are often viewed as poorly educated, outwardly aggressive males, who are unable to achieve sexual gratification through normal outlets.

Sexual assault can occur anytime, anywhere, and to any person. Thirty-three percent of rapes occur in the victim's home. Victims of rape come from all walks of life, and rapists are often educated, married, and have healthy sex lives. Sexual assault is probably the most myth plagued crime.

Because of the "sexual" element present, the real motive of rape often goes unnoticed. With sexual assault, as with physical assault, power, control, and humiliation are the primary goals. In most cases of rape, sexual gratification is secondary or nonexistent.

Because of myths, misinformation, and an incomplete understanding of rape, people once believed that sexual assault could not occur between friends, lovers, or spouses. It was not until the late 1970's and early 1980's that the concept of acquaintance or date rape raised public interest. Since then, researchers have looked into the causes, effects, and occurrences of date rape in our society, with students from universities and colleges serving as research populations.

A problem that still presents difficulty is the definition of rape or sexual assault. For clarity and ease of reading, the terms rape and sexual assault will be used to refer to all adult non-consenseual sexual acts. These include vaginal, anal and oral intercourse, fondling, or any unwanted sexual attention, that uses physical, verbal threats, or emotional coercion. Acquaintance or date rape will refer to sexual assault where the victim knows the perpetrator. Table 1 gives an easy way of defining sexual assault.

TABLE 1.

	Consenting	Non-Consenting
Does Not Know Partner	SEX	SEXUAL ASSAULT
Knows Partner	SEX/ LOVEMAKING	SEXUAL ASSAULT (DATE RAPE)

[1]

Acquaintance rape has recently become a major concern on college campuses. Most university administrators are now accepting the fact that rape does occur at their institutions, and are working to educate students about prevention and provide professional services for victims.

The Problem

* One out of every four college females reports being the victim of a sexual assault or an attempted sexual assault. Of this sample one third said they would date their assailant again.

* One out of every ten college females will be the victim of a sexual attack.

* Most victims will not report the assault. It is estimated that from 50% to 90% of all sexual assaults go unreported.

* The majority of rape victims know or have dated their attacker.

* About one third (1/3) of sexual assaults will take place in the victim's home or apartment.

* College students commit four out of every five sexual assaults that occur on college campuses.

* One third of college men report that they would sexually assault a female if they knew they could get away with it.

* First semester Freshmen are more likely to be victims of a rape by an upper classman.

* A large number of rapes are committed by close-knit male groups like athletic teams or all male organizations

Preventing Sexual Assault

Although sexual assaults may not ever be eliminated they can be reduced. Prevention does require educating females about date rape warning signs. Additionaly we must also teach males to respect the rights of females, and females to be more assertive about their own rights.

College students need to become aware of the major factors that play a role in date rapes.

1. Use of alcohol and/or drugs, usually to excess.

2. The myth that when a woman says "NO" she really means "YES".

3. The myth that a man must persuade a women to have sex until she finally realizes how good it feels and quits protesting.

4. Miscommunication about exactly how far sexual activity should go.

5. A female suddenly stops sexual activity, but is unwilling to discuss reasons for stopping or males feelings of frustration and anger.

6. The myth that a male needs to be sexually active to be masculine.

7. The myth that females should compensate males for money spent on a date by granting sexual favors.

8. The myth that if a female is sexually active she will have sex with any male.

Changing Attitudes

Prevention experts, therapists and researchers all agree that changing attitudes of both males and females is necessary. It is important to realize that socialization plays a role in sexual aggression. By re-socializing or changing current beliefs, some sexual assaults can be avoided.

Some attitudes that males need to change are listed below:

1) Forced or coerced sexual activity is never justified, no matter what the situation, even if:

   a) she teases you,
   b) you have had sex with her before,
   c) you bought her an expensive dinner or gift,
   d) she dresses provocatively,
   e) she has been drinking heavily, or
   f) you think she needs to be persuaded.

2) Males need to recognize that the motivations for rape include power, control, and domination, not sexual gratification.

3) The word "NO" means "NO".

4) Your sexual desires may be beyond your control, but your behaviors are within your control. Just because you are aroused does not give you the right to force intercourse.

5) Be aware that your physical size is intimidating. This can create fear in a woman and may cause her not to resist. <u>Not all rape victims fight back.</u>

6) If a female is drunk she can not give viable consent, therefore taking sexual advantage of a drunk female is rape. Also, being drunk yourself is no excuse for committing rape.

7) When a woman rejects your sexual advancements, she is not rejecting you. Remember, it is O.K. not to "score."

8) Respect a woman's rights to stop sexual activity at anytime. Also, be willing to discuss her right to stop. That means no pressure or debate.

9) Never assume that a woman wants to have sex. Ask her and be willing to discuss alternatives to intercourse. But remember "NO" always means "NO."

10) Communicate feelings and desires clearly. If you have doubts about your desires or her wants, stop all behavior and talk about the situation. STOP, TALK, CLARIFY.

Attitudes that females need to portray are listed below:

1) You have the right to say "NO" and not be pressured into unwanted sexual activity.

2) Be clear about your sexual desires, and communicate them clearly. If all you want to do is engage in petting, then say so.

3) Take a more active role in your dates. Give input to where you want to go and what you would like to do on the date.

4) You have the right to end a date at anytime without feeling guilty. Take cab fare or phone money so you can get home.

5) You have the right not to drink on a date, but if you do, be aware of how alcohol can effect your judgment.

6) Although poor judgment is not a rapeable offense, females need to be more aware of risky behavior and avoid potential dangerous situations.

7) You have the right to yell, hit, scratch, bite, kick, or cause any bodily harm to a male who is attempting a sexual assault.

8) You also have the right to be heard, helped and supported if you are a victim.

9) Pay attention to warning signs in relationships. Date rapes even occur in long-term relationships as well as first time dates.

a) Partner has general disrespect and hostility towards

b) Partner places you on a pedestal or sets high standards for you, and becomes angry when you don't live up to them.

c) Partner controls relationship, he does not respect your ideas, or consults you about dates.

d) Partner becomes angry or tries to make you feel guilty when you turn down his sexual advancements.

e) Partner is overly intrusive into your personal space, and does not respect your right to privacy or your personal sexuality.

f) Partner becomes physically or verbally abusive when drinking.

g) Partner uses emotional coercion or emotional blackmail (i.e."If you loved me you would...").

Three Phases of a Date Rape

Researchers and counselors have identified three stages of date rape. They include intrusion, desensitization, and isolation.

Intrusion During this phase the offender attempts to make the victim feel uncomfortable. By doing so he tests to see if she will remain even though he evades her physical or psychological space. He does this by using unwanted touches, looks that make the victim uncomfortable, and very personal conversation, (the perpetrator will ask personal questions about past sexual activity).

Desensitization This stage happens when the female has dropped her guard and accepts the male's intrusive behavior as normal for him. During this phase, she consciously represses or denies any of her feelings of uneasiness. During this phase, she may rationalize away her feelings of fear in order to be polite or so as not to hurt his feelings. During this time, they may have engaged in some sexual activity like kissing or light petting.

Isolation The male will try now to isolate the victims from others. Once this happens, the perpetrator may use emotional coercion and the fact that other sexual activity has occurred to justify sexual intercourse. If this fails, the offender may resort to physical and verbal threats to gain intercourse. Remember, the key factor here is the rapist wants power and control over the victim.

Trauma

Many rape victims equate being raped with being shot or stabbed. A victim of a sexual assault has been exposed to a traumatic personal violation. Try to imagine a sexual behavior that is normally associated with love, caring, and trust. Rape associates this act with feelings of distrust, pain, hate, and anger.

Rape trauma like any other trauma produces short-term as well as long-term reactions. The initial response of most victims (when they realize they are being raped) is one of disbelief. Soon the individual comprehends the situation. At this point the victim may become hysterical or may freeze. The survival instinct then takes over and the person may fight back or succumb to the assault. The following outlines the stages of the Rape trauma response and Posttrauma recovery cycle.

Rape Trauma Response

The attack
Disbelief
Realization of the reality of the attack
Cognitive survival state

[Release or Escape]

Posttrauma Recovery Cycle

Shock
Denial of what happened
Mood swings
Anger
Philosophical reflection
Laying to rest
[2]

Long-term effects come in different forms. In some cases the victim is able to hide any outward signs of the attack. However, a future event later may trigger the memory of the assault and will produce dysfunctional behavior in the victim. Behavior changes that an individual may experience after a sexual assault:

1. Sudden drastic personality change (i.e. introvert becomes an extrovert).

2. Rapid drop in school and or work performance.

3. A social withdrawal, that may include activities the individual greatly enjoyed.

4. Promiscuous behavior. (This is often common for females who were virgins at the time of the rape).

5. Self-mutilation or self destructive behavior.

6. General distrust of strangers, especially males. If the perpetrator was an acquaintance the female may fear and distrust all males.

7. Increase in drug and/or alcohol use.

8. Anorexic and bulimic behavior.

9. Depression and suicidal behavior.

10. Sudden change in peers and social groups.

11. Hysterical crying, panic attacks, or inappropriate affect.

12. Loss of self-worth, and self-esteem.

13. Obsessive and compulsive behaviors. Concerned with security.

14. Inability to form relationships.

15. Sleep disorders. (insomnia, nightmares).

16. Sexual dysfunctions.

How to help a Victim

Working with a rape victim requires patience and personal strength. It is important however to place the safety of the victim first. The victim has been through a trauma in which she has been overpowered and made temporarily helpless. At this time, victims will attempt to make cognitive sense of the situation as well as try to establish control again. Helping the victim by minimizing any other shock or surprises becomes essential. However, you must not attempt to take control of a victim's life - this will only prolong the feelings of helplessness. Talk with and allow the victim to be a part of the decision making process for medical attention, reporting the assault, and seeking treatment. But most of all, get in touch with the Counseling Center on campus. Call 357-5621 and ask to speak to David Ensminger or Bridget Poleman. If contact is after University hours, call University Police. They will place you in touch with one of the University's Counselors.

The following are steps to follow in helping a sexual assault victim.

1) Encourage victim to seek medical assistance. Even though there may be no obvious medical problem, issues like internal bleeding, pregnancy and STD`s need to be considered. In addition the hospital exam will include the collection of evidence for future prosecution.

2) Immediately contact a professional counselor or rape crisis hotline (i.e. Call Counseling and Career Services. David or Bridget).

3) Do not allow the victim to bathe, douche, or change clothes. This destroys evidence. Bring clean clothes to the hospital, the old clothes will be kept for evidence.

4) Don't blame the victim! No matter the circumstance, no one asks to be raped. Encourage victims to not blame themselves. Point out the fact that they can not control another person's behavior. <u>However, avoid debate and argument with the victim.</u>

5) Report the attack. Reporting a rape, does not mean you are pressing charges. Attackers are less likely to come back if you report the crime.

6) Provide comfort and stability to the victim. Do not ask specific questions about what happened. All you need to know is that the victim was sexually assaulted.

7) Listen to what the victim tells you, this may help the police later.

[1] Adapted from Acquaintance Rape, The Hidden Crime, Andrea Parrot and Louise Bechhofer, John Wiley & Sons, Inc. , 1991.

[2] From Sexual Trauma in Children and Adolescents, Diagnosis and Treatment, Diana Sullivan Everstine, Louis Everstine, Brunner/Mazel 1989.